



State, Society & Governance in Melanesia

Celebrating 20 years of SSGM and 70 years of Pacific studies at The Australian National University

Indigenous Women, Antenatal Care and Childbirth in Papua, Indonesia

Jenny Munro

In Brief 2016/22

This In Brief presents some preliminary findings from qualitative research in progress on Papuan women's use of health services for antenatal care and delivery. Papua presents the worst maternal and infant mortality rates in Indonesia, and indigenous Papuans experience poorer health than Indonesian migrants (BPS 2012). Maternal mortality is estimated at 362 per 100,000 live births compared to a national average of 220 per 100,000 live births (IPPA 2013). However, actual rates are probably higher due to under-reporting and lack of services in remote areas. Papuan women, most of whom live in rural areas, are less likely to have babies delivered by skilled personnel in a clinic or hospital than migrant women (BPS 2012:16).

There is a pressing need to better understand experiences of antenatal care and childbirth services in Papua because of epidemic levels of HIV and active syphilis (Munro 2015), and because these services provide an opportunity to engage indigenous women and men in the health system in a context where state-indigenous relations are fraught. Papua presents some particular complexities in relation to reproductive health and state interventions. Historically, the Indonesian government has conflated reproductive health with the use of modern contraception or 'family planning', which has led to a backlash among some Papuans who argue that they are becoming a minority in their own land (Butt 2001). Indigenous-run services, while rare, are actively trying to change these conditions and promote culturally compelling approaches to health (Munro 2014).

This research aimed to develop an understanding of when and why indigenous women and men seek antenatal care and supervised childbirth, including their perceptions of the quality of services and direct or indirect experiences with antenatal care and supervised delivery. This research builds directly on recent research with HIV-positive indigenous mothers which showed that women do not receive appropriate care and services (Munro and McIntyre 2016). So far I have spoken with six Dani mothers aged 20–30 years old from the central

highlands city of Wamena who were living in Wamena or in Jayapura, the provincial capital. The women were all living in areas where geography was not a barrier to using health services. All but one had given birth within the past two years. Three had no formal education, one had finished her first year of high school, and two had finished a year of university studies.

Preliminary analysis reveals several themes. First, women were not opposed to using health services for antenatal care and delivery. Four of the women delivered at the hospital for their first childbirth. Second or third babies were delivered at home with the help of relatives. This was true regardless of whether the mothers were younger or older, lived in Wamena or Jayapura, and whether they were educated or not. Only one of the women had never used health services for pregnancy or birthing.

Besides health services, women described seeking antenatal care from an indigenous woman (usually aged 40–60) who was known for being skilled at helping with pregnancy and delivery. This woman would massage the mother's stomach on several occasions before the birth, and was said to help to get the baby into the head-down position for delivery. She would also support during delivery, including by preparing herbal medicines.

Second, negative experiences with health services are a deterrent to seeking care in second or subsequent pregnancies and deliveries. One mother said that the nurses were harsh with her and when the baby crowned they refused to take it out. When she complained they said "Did you think giving birth wouldn't hurt?" They waited until the doctor came ... the doctor lifted my legs and the baby shot right out.' So her second baby was born in the village with her older sister helping. Another participant who had her first child at the hospital said she was concerned that, 'at the hospital, if you take too long to deliver, they will deliver it by an operation [caesarean section], that's why I don't feel like going there.' Women had little to no postnatal assistance on newborn

care or their own health even though one woman had had an episiotomy.

Women's use of health services was also shaped by their understanding of the social aspects of pregnancy and delivery. Premarital pregnancies were kept secret to avoid shame and the anger of relatives (Butt and Munro 2007), and this may have an effect on women's decisions to seek antenatal care. Four of the women said they hid their first pregnancy from one or both of their parents or other relatives because they were unmarried at the time. One of them attended antenatal care, and the staff at the health post informed her father about the pregnancy. She ran off and stayed with the baby's father until she went into labour. She tried to deliver at his home with his relatives helping but found the pain became too much for her as 'too many people were telling me what to do' and she asked to be taken to the hospital.

Difficult labour and deliveries were often attributed to some sort of conflict, social imbalance or previous wrong by the mother, father or other relatives (living or deceased). Women recounted telephoning their father or mother while in labour to set things right so that the baby would be born. One woman said, 'It was taking a long time because mama was still angry at me, mama wouldn't pray for me'. In this case the pregnancy was premarital and had been kept secret from her mother and father. Another woman's child had died in hospital the day after he was born, and the mother suggested that a disgruntled relative who also died that week had occasioned the infant's death. She said it would be safer to give birth at home where she and her husband had relatives around them to protect her and the baby.

These themes require further investigation. It is interesting to note that women are open to health services, but that these appear unattractive in their current form. Health services are not well equipped to deal with situations of hidden, premarital pregnancies, if staff do not maintain confidentiality. Premarital pregnancies appear to present higher risks as women are less likely to seek any support. Contraceptive options are limited for unmarried couples, and sex education patchy at best, but overall there is a strong pro-fertility emphasis among highlanders that can be leveraged towards engaging indigenous women in health services. The significance of social relations and the social environment of childbirth should be considered in health service improvements, along with sensitivity to previous indigenous trauma with health services and ongoing discrimination against indigenous clients (Munro and McIntyre 2016).

Author Notes

Jenny Munro is a research fellow in the State, Society and Governance in Melanesia Program, ANU.

Endnote

1. In 2011–2012 I also encountered indigenous concerns about what many perceived to be a rising occurrence of delivery by caesarean section among Papuan women. Interpreted in relation to ongoing state violence and indigenous resistance, some said that risky procedures being conducted on Papuan mothers was further evidence of the Indonesian state's neglect and/or ill will towards the indigenous population.

References

- BPS (*Badan Pusat Statistik*; Statistics Indonesia) 2012. [Multiple Indicator Cluster Survey: Selected Districts of Papua and Papua Barat](#).
- Butt, L. 2001. KB Kills: Political Violence, Birth Control, and the Baliem Valley Dani. *The Asia Pacific Journal of Anthropology* 2(1):63–86.
- Butt, L. and J. Munro 2007. Rebel Girls? Unplanned Pregnancy and Colonialism in Highlands Papua, Indonesia. *Culture, Health & Sexuality* 9(6):585–98.
- IPPA (Indonesian Planned Parenthood Association) 2013. [Continuum of Care for Pregnant Women in Indonesia](#). London: International Planned Parenthood Federation, Japan Trust Fund for HIV and Reproductive Health.
- Munro, J. 2014. [Report from the Field: HIV/AIDS in West Papua, July–Sept 2013](#). SSGM Working Paper 2014/1. Canberra: ANU.
- Munro, J. 2015. [The 2013 Survey on HIV in Tanah Papua: Gender, Ethnicity and 'Casual Partners'](#). SSGM In Brief 2015/11. Canberra: ANU.
- Munro, J. and L. McIntyre 2016. (Not) Getting Political: Indigenous Women and Preventing Mother-to-Child Transmission of HIV in West Papua. *Culture, Health & Sexuality* 18(2):156–70.

